SC Department of Disabilities & Special Needs

Pervasive Development Disorder Program

Early Intensive Behavioral Intervention (EIBI) Services

Provider #:		Provider Name:	
Consumer:		Client SSN#:	
Medicaid #:		Date Range	__/__/____ to __/__/__

A) EIBI Annual Assessment - Code H0031: Partial Asse[illegible]nt – Code H[illegible]2

Assessment Type	Service Amount	Rate	[illegible]mount Due
Annual 1 per year		$2,100.00	
Partial up to 15 hours		$60.00/hr	

B) EIBI Line Therapy - Code H0046

Maximum 40 hours per week with a maximum [illegible]day

Week	Mon	Tue	Wed	Thu	Fri	Sat	Sun	T[illegible]	Rate	Amount Du[illegible]
1st									$14.00/hr	
2nd									$14.00/hr	
3rd									$14.00/hr	
4th									[illegible]0/hr	
5th									$[illegible]	
Totals									//////////	

C) EIBI Lead Therapy - Code G0177

M[illegible]hours per week

Week	Mon	Tue	Wed	Thu	Fri	[illegible]	Sun	Total	Rate	Amount Due
1st									$30.00/hr	
2nd									$30.00/hr	
3rd									$30.00/hr	
4th									$30.00/hr	
5th									$30.00/hr	
Totals									//////////	

D) EIBI Plan [illegible]plement[illegible]on - [illegible]H[illegible]32

Ma[illegible]hours per month

	Date	Date	D[illegible]	Date	D[illegible]e	Date	Date			
Day								Total	Rate	Amount Due
Hours									$60.00/hr	

[illegible]FICATION: [illegible]units of service reported above have been provided in accordance with the policies and p[illegible]edures for the Pervasive Developmental Disorder Waiver.

_____ _____

Signature Date